FORM 73437
1/99

CERTIFICATE OF INSURANCE

This is to certify to Bechtel Bettis, Inc. that the insured name below is at this date insured with

_____

(hereinafter referred to as the "Insurer") in the extent described herein:

Name and Address of the Insured:_____

_____

TYPE OF INSURANCE COVERAGE	POLICY NO.	POLICY PERIOD
COMPREHENSIVE GENERAL LIABILITY (INCLUDING CONTRACTUAL LIABILITY 1. Bodily Injury and Property Damage, combined single limit $500,000……..		
AUTOMOBILE LIABILITY 1. Bodily Injury, with limits of not less than $300,000/$500,000…… 2. Property Damage, with a limit of not less than $100,000……		
EXCESS LIABILITY (IF APPLICABLE)		
WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY 1. Workers' Compensation, Statutory…….. 2. Occupational Disease, Statutory…….. 3. Employer's Liability, with limits of not less than $100,000…….. 4. Medical, Statutory……..		

The insurance coverage described herein specifically applies to all work performed by the insured at the (☐ Bettis Atomic Power Laboratory, ☐ Naval Reactors Facility) of Bechtel Bettis, Inc., in accordance with the following purchase order between the insured and Bechtel Bettis, Inc.: -

_____

The insurer certifies that all the insured's policies described herein exclude, by appropriate language, any claim by the insurer to be subrogated, except as to Workers' Compensation in those states prohibiting the waiver of the insurer's right of subrogation of Workers' Compensation insurance, on payment of loss or otherwise, to any claim against Bechtel Bettis, Inc. or the U.S. Government.

The Insurer agrees not to cancel nor to make any material change whatsoever in the policies described herein that adversely affect Bechtel Bettis, Inc.'s and the Government's interests except upon thirty (30) days prior written notice thereof to:

☐ Bettis Atomic Power Laboratory
Post Office Box 79
West Mifflin, PA 15122-0079
Attn: Procurement Dept.

☐ Naval Reactors Facility
Post Office Box 2068
Idaho Falls, Idaho 83401-2068
Attn: Procurement Dept.

Name and Address of Insurer:

_____

_____

_____

Name and Address of Insurer's Authorized Representative

_____

_____

_____

Signature _____Date_____
Insurer's Authorized Representative